REVISION DATES: 08/03/2015; 12/15/2014; 09/11/2013; 05/31/2012

NOTE: The covered services, limitations, and exclusions described in this chapter provide general guidance to providers. For a more comprehensive, updated summary of AHCCCS coverage and requirements, please review Arizona Administrative Code (A.A.C.) R9-22-201 et seq and the AHCCCS Medical Policy Manual (AMPM). More detailed information regarding DME, supplies, orthotics, and prosthetics may be found in the AMPM Policy 310-P available on the AHCCCS web site at www.azahcccs.gov

Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Medical Policy and Coding at (602) 417-4066.

## OVERVIEW

AHCCCS covers reasonable and medically necessary medical supplies, durable medical equipment (DME), orthotics and prosthetic devices when ordered by a primary care provider, a practitioner, or dentist within certain limits based on member age and eligibility.

For purposes of this policy:

- Medical supplies are consumable items that are designed specifically to meet a medical purpose.
- DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in absence of a medical condition, illness or injury.
- Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace a missing, deformed or malfunctioning portion of the body. Prosthetics are covered within limitations when medically necessary for rehabilitation.
- Orthotics are devices prescribed by a physician or other licensed practitioner to support a weak, injured or deformed portion of the body.

DME is used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member's home.

Personal care items are not covered unless needed to treat a medical condition. The AHCCCS program covers incontinence briefs for members over age 3 and under age 21 as described in the AMPM Policy 430. Except for incontinence briefs as described in

Policy 430, personal care items are not covered for members over age 3 and under age 21 solely for preventive purposes. Personal care items include items of personal cleanliness, hygiene and grooming.

Personal care items are not covered unless needed to treat a medical condition. The AHCCCS program covers incontinence briefs for ALTCS members over age 21 as described in the AMPM Policy 310-P. Refer to Policy 310-P for requirements, limitations and exclusions. Except for incontinence briefs as described in Policy 310-P, personal care items are not covered for members over age 21 solely for preventive purposes. Personal care items include items of personal cleanliness, hygiene and grooming.

**For all AHCCCS recipients, no separate payment is made for DME supplied as part of a hospital inpatient admission or outpatient treatment.**

Payments for Durable Medical Equipment (DME) provided to AHCCCS members during inpatient hospital stays or outpatient hospital visits are generally included in the hospital inpatient rate or OPFS rate payments.

Any DME supplied to an AHCCCS member as part of the treatment the member receives during an inpatient hospital admission is included in the hospital's reimbursement rate, even if on discharge the member takes the DME home for continued use. No separate payment for that DME may be made to the hospital or DME supplier by AHCCCS or its Contractors.

Non-covered prosthetic/orthotic devices are not included when determining whether an inpatient stay qualifies as an outlier.

If an inpatient stay does qualify as an outlier without considering charges for non-covered devices, the charges for those devices are not included in the outlier payment calculations.

Similarly, any DME supplied to an AHCCCS member as part of an outpatient visit is included in the OPFS rates and should be included on the bill from the Outpatient facility, even if on conclusion of the visit the member takes the DME home for continued use.

Under some circumstances, DME provided to AHCCCS members during inpatient stays or outpatient visits may be billed separately by suppliers and paid by AHCCCS or its Contractors. DME suppliers may submit separate claims for DME provided to an AHCCCS member while an inpatient in a hospital facility if that DME was provided to facilitate discharge of the member from the hospital and was neither necessary for nor used as part of the treatment the member received while an inpatient. In general, such

equipment is provided close to the date of discharge and is not used in the hospital except to the extent necessary to achieve proper fit of the DME or training to assure its safe use upon discharge.

In the absence of a showing to the contrary, DME provided inpatient more than two days prior to discharge is presumed to have been used as part of the treatment or recovery of the member during the hospital stay and may not be claimed separately by the hospital or DME supplier.

## COVERED SERVICES: UNDER THE AGE OF 21

For members under age 21 DME, orthotics, prosthetics, and supplies are covered under EPSDT when medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions whether or not the services are covered in the State Plan. Please refer to Policy 430 in the AMPM for more information about EPSDT.

Covered services for persons under the age of 21 include:

1. Medical supplies
   Surgical dressings, splints, casts, and other consumable items, which are not reusable and are designed specifically to meet a medical purpose.
2. Durable Medical Equipment (DME)
   a. Sturdy, long lasting items and appliances that can withstand repeated use, serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness, or injury.
   b. Covered DME includes wheelchairs, walkers, hospital beds, bedpans, and other durable items that are rented or purchased.
3. Prosthetic devices such as artificial upper and lower limbs
4. Orthotics devices such as orthosis devices for the spine including cervical collars; upper and lower limb orthotic devices such as Ankle Foot Orthosis (AFO) and Wrist-Hand Finger Orthosis (WHFO).

## COVERAGE LIMITATIONS AND EXCLUSIONS: UNDER THE AGE OF 21

The following criteria must be used in determining coverage:

1. Medical necessity in setting up and/or maintaining the member in the most appropriate setting while maximizing the members independence and functional level both physically and mentally, and
2. The most cost effective alternative to provide medically necessary services in the most appropriate setting while maximizing the member's independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative sources where the equipment can be obtained at no cost.

Total expense of the rental must not exceed the purchase price of the item.

Rental fees must terminate no later than the end of the month in which the recipient no longer needs the medical equipment as certified by the authorized provider or when the recipient is no longer eligible, except during transitions as specified by the AHCCCS Chief Medical Officer or designee.

DME and supplies are an ALTCS-covered service for recipients receiving Home and Community Based Services (HCBS). DME and supplies are also covered for recipients residing in nursing facilities if they are not included under the facility's per diem rate and if ordered by the a physician or primary care practitioner and approved by the case manager.

Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

Incontinence briefs are covered for children over age 3 and under age 21 as described in the AMPM Policy 430 and AHCCCS Rules.

Personal incidentals, including items for personal cleanliness, body hygiene, and grooming, are not covered except to treat a medical condition under a prescription.

First aid supplies are not covered except under a prescription.

## COVERAGE LIMITATIONS AND EXCLUSIONS: AGE 21 YEARS AND OLDER

The following criteria must be used in determining DME coverage for members age 21 years and older:

1. Medical necessity in setting up and/or maintaining the member in the most appropriate setting while maximizing the members independence and functional level both physically and mentally, and

2. The most reasonable and cost effective alternative to provide medically necessary services in the most appropriate setting while maximizing the member's independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative sources where the equipment can be obtained at no cost.

Total expense of the rental must not exceed the purchase price of the item.

Rental fees must terminate no later than the end of the month in which the recipient no longer needs the medical equipment as certified by the authorized provider or when the recipient is no longer eligible, except during transitions as specified by the AHCCCS Chief Medical Officer or designee.

DME and supplies are an ALTCS-covered service for recipients receiving Home and Community Based Services (HCBS). DME and supplies are also covered for recipients residing in nursing facilities if they are not included under the facility's per diem rate and if ordered by the attending physician or PCP and approved by the case manager.

Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

**The following are excluded except as otherwise specified below:**

1. Incontinent supplies except as outlined previously in this chapter.
2. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming, except to treat a medical condition under a prescription.
3. First aid supplies except under a prescription,
4. Hearing aids
5. Prescriptive lenses except when they are the sole prosthetic after cataract removal.
6. Penile implants or vacuum devices

7. Bone Anchored Hearing Aids (BAHA), also known as Osseointegrated implants
8. Cochlear implants
9. Insulin pumps
10. Percussive vests
11. Microprocessor controlled lower limb or microprocessors controlled joints for lower limbs.

**Factors for coverage of a lower limb prosthetic (excluding microprocessor-controlled) include but are not limited to:**

1. Consideration of the member's:
    a. Past history (including prior prosthetic use, if applicable)
    b. Current condition (including status of the residual limb and the nature of other medical problems)
    c. Degree of motivation to ambulate with a prosthetic, and
2. Assessment of the member's functional level as described below (please note that within the functional classification hierarchy, bilateral amputees often cannot be strictly bound by functional level classifications):

| | |
|---|---|
| **Level 0** | Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. |
| **Level 1**: | Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence typical of the limited and unlimited household ambulator. |
| **Level 2** | Has the ability or potential for ambulation with the ability to traverse low-level environment barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator. |
| **Level 3**: | Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. |
| **Level 4** | Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. |

### Limitations for lower limb prosthesis

1. Lower limb prosthesis is not considered medically necessary for members with a functional level of 0.
2. If more than one prosthetic device can meet the enrollee's functional needs, benefits are only available for the prosthetic device that meets the minimum specifications for the member's needs.

### Limitations for Orthotics

Effective 08/01/2015 orthotics are covered for age 21 years and older when the use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines and the orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.

Orthotics must be prescribed by a physician (MD/DO) or primary care practitioner (PA, NP).

Orthotics are covered with Prior Authorization when all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines; and
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition; and
- The orthotic is ordered by a physician or primary care practitioner.

## EQUIPMENT MAINTENANCE AND REPAIR

Equipment maintenance and repair of component parts is allowable for AHCCCS covered prosthetics. Components will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

## BILLING AND AUTHORIZATION REQUIREMENTS

DME revenue codes are not reimbursable to hospitals on the UB-04 claim form.

Items must be correctly coded as medical/surgical supplies, or if DME, billed on the CMS 1500 claim form.

Procedures related to DME cannot be interpreted without modifiers that describe the type of service and payment arrangement made. Without an appropriate modifier the claim will be denied.

The appropriate modifiers are:

| | |
|---|---|
| LL | lease/rental |
| NR | new when rented |
| NU | new equipment |
| RA | replacement of DME item |
| RB | replacement of part of a DME |

All DME (rentals and purchases), prosthetic/orthotic devices, and medical supplies for ALTCS recipients require authorization (PA) from the recipient's case manager.

All DME rentals for acute care recipients require prior authorization from the AHCCCS Utilization Management/Care Management (UM/CM).

PA also is required for DME purchases and for prosthetic devices when the purchase price for the item exceeds $300.00 for acute members and $500.00 for ALTCS members.

Consumable medical supplies (supplies that have limited potential for re-use) require PA when the charge for such supplies exceeds $100.00 per month.

All orthotics for recipients age 21 years and older require prior authorization as indicated in the section above.

Providers who bill for apnea management, training, and the use of the apnea monitor must use procedure codes E0618-E0619 (apnea monitor) and the RR modifier.

The total charge billed to AHCCCS must include management, training, and use of the apnea monitor.

Apnea management and training services may not be billed using procedure code 94799 (Unlisted pulmonary service or procedure).

## References:

Refer to AMPM:

Policy 310-P for further information related to Orthotics

Policy 310-P for Incontinence Briefs, Medical Supplies, DME and Prosthetic Devices

Policy 430 for EPSDT Services

Chapter 800 for prior authorization requirements for Fee-For-Service (FFS) providers

Chapter 1200 for further information related to ALTCS and HCBS

Revisions/Update History

| Date | Description of changes | Page(s) |
|---|---|---|
| 08/03/2015 | Chapter renamed;<br>Orthotics benefit changes effective 08/01/2015 for adults | 7 |
| 4/22/2015 | New formatting;<br>Incontinence briefs benefit changes retro-effective 12/15/2014 | All<br>2 |